



# IAC

## Individual Assurance Company

LIFE, HEALTH & ACCIDENT

P.O. Box 14533  
Oklahoma City, OK 73113  
1-888-524-3629

### REQUEST FOR SERVICE

POLICY NUMBER		INSURED	MEDICARE ID NUMBER
MPOLICY		MINSNAME	
CHANGE NAME OF: <input type="checkbox"/> Insured <input type="checkbox"/> Payor			
FORMER NAME (please print)		NEW NAME (please print)	
REASON FOR CHANGE (If other than correction, marriage or divorce, please attach copy of legal evidence; if available.)			
<input type="checkbox"/> DUPLICATE POLICY REQUEST		<input type="checkbox"/> DUPLICATE ID CARD REQUEST	
<input type="checkbox"/> CHANGE OF ADDRESS (Indicate new address.)		<input type="checkbox"/> CANCELLATION OF FREE LOOK	
		<input type="checkbox"/> CANCELLATION OF POLICY	
<input type="checkbox"/> CHANGE OF TELEPHONE NUMBER (Indicate new telephone number.)		<input type="checkbox"/> NOTIFICATION OF DEATH (Please include death certificate)	
<input type="checkbox"/> CHANGE PAYMENT METHOD  <input type="checkbox"/> QUARTERLY DIRECT <input type="checkbox"/> SEMI-ANNUAL DIRECT <input type="checkbox"/> ANNUAL DIRECT <input type="checkbox"/> MONTHLY EFT <input type="checkbox"/> QUARTERLY EFT <input type="checkbox"/> SEMI-ANNUAL EFT <input type="checkbox"/> ANNUAL EFT  <b>*IF selecting EFT option please contact a Customer Service Associate at 1-888-524-3629.</b>		<input type="checkbox"/> REQUEST TO REDUCE/INCREASE BENEFITS  <input type="checkbox"/> Basic <input type="checkbox"/> Medicare Part A Deductible Rider <input type="checkbox"/> Medicare Part B Excess Charge Rider <input type="checkbox"/> Home Health Care Rider <input type="checkbox"/> Foreign Travel Emergency Rider <input type="checkbox"/> Medicare Part B Deductible <b>or</b> <input type="checkbox"/> Part B Copayment Rider  <b>*ALL benefit changes are subject to underwriting approval and state regulation.</b>	
COMPLETE FOR ABOVE REQUEST			
_____ Signature		_____ Date	